Editorials

In the Meantime

HEALTH CARE REFORM is years away. In the meantime, we have health care revolution. As with all revolutions, important matters are not receiving enough attention. One of the most neglected issues is the fate of medical education and research and of teaching institutions. There is plenty of talk about the training of specialists and subspecialists. What about medical students? Surely we have not seen the last of physicians who take simple pleasure in listening to patients (and their hearts) because they can discover important information from the endeavor.

Glaser is concerned that the lack of intense, long-term hospital experience will impair students' abilities to learn how to do a thorough history and physical examination and to learn the natural history of disease.[1] Perhaps rotations through hospices, nursing homes, rehabilitation centers, and home care programs could help.

Aside from the teaching site, however, who will teach medical students the art of history taking and physical diagnosis? We know that these outshine all of technology in determining a patient's diagnosis and prognosis.[2] Who will teach patient education and counseling? Who will teach warm-hearted skills that build trust and are essential to healing? Who will teach about values and practical ethics? As primary care clinicians rush through an increased load of patients, will subspecialists be willing or able to teach the basics? Is there a place for displaced physicians, for physicians with superlative skills who take good care of patients in the old-fashioned way—with more time and less technology—to teach medical students and house officers? Should these and other teachers be paid for teaching time away from their office practices when they thereby lose income? Who will pay them?

Another threatened essential is clinical research. We must continue to learn so we can contend better with the known and unknown. Science has not conquered nature. Some enterococci now respond to no single antibiotic or combination of antibiotics. Multiple drug-resistant tuberculosis is killing patients and health care workers. Breast and prostate cancers are epidemic, and we know neither cause nor cure. The only recourse is research. Yet, as Cadman notes, the research productivity of young physician-investigators is threatened by pressure to support themselves by caring for patients and by their impaired opportunity to obtain grants, since renewal grants are four times more likely to be awarded than new ones.[3] Solutions may include developing a new national research strategy, providing more support (money and moral), and teaching the principles and practice of clinical investigation at all levels of medical training.

During this "meantime," what will become of academic medical centers? To serve our country's needs best, these centers must continue their teaching and research programs. Now, under managed care, the expense of treating patients can drain resources away from house staff education and continuing education. Funds are being shifted from investing in the future to protecting the present. Every incentive is away from caring for the most vulnerable, the most afflicted, the most needy. But if physicians in these centers do not provide care for sick patients and continue searching for clinical advances, who will? Will risk-adjusted payments come soon enough? Will they be adequate?

What is happening now to America's teaching institutions? A dangerous downward spiral seems to be swirling them into debility. There may be a subtle yet deadly falter in our education and research momentum. Newly minted health maintenance organizations (HMOs) and corporations determined to save money simply do not see teaching and research as their social responsibilities. No level of government is stepping in to help. As patients respond to the federal government policy of encouraging entry into Medicare HMOs, existing support of medical education drops. We, therefore, find with surprise and dismay that the future of our very foundation—teaching and research in academic medical centers—is at risk. Some have said that if economics continues eroding education, research, and the care of patients, there will be little left of medicine to reform by the time health care reform is under way.

Those who understand the risks our patients and their families face must insist that medical education and progress be high priorities. We simply must raise these issues to greater visibility. We cannot coast on past victories. Policymakers and the public may not appreciate the lag time between recognizing a problem, discovering a solution, and applying a new approach safely and effectively. They may not know that basic science, or the rain forest, may have clues that even precede recognition of a problem. To scale the peaks looming above us, we must recognize the need for the partnership of medical education and research, insist upon it, and form coalitions with our patients and others so we can pull and push each other along. We must use this "meantime" to work on a healthy future.

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REFERENCES

1. Glaser RJ: Health care reform and academic medical centers. Pharos 1994; 57:40
2. Peterson MC, Holbrook JH, Hales D, Smith NL, Staker LV: Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. West J Med 1992; 156:163-165
3. Cadman EC: The academic physician-investigator: A crisis not to be ignored. Ann Intern Med 1994; 120:401-410

Perioperative Cardiac Morbidity—Epidemiology, Costs, Problems, and Solutions

THE REVIEW ARTICLE by Darryl K. Potyk, MD, in this issue of THE WESTERN JOURNAL OF MEDICINE addresses a timely and important subject.[1] Before discussing some of the issues brought up by Dr Potyk, I think it worthwhile to review the importance of the problem of perioperative cardiac morbidity.